Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

RAYMOND GLASS DC
3100 TIMMONS LANE STE 250
HOUSTON TX 77027

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

TEXAS COUNCIL RISK MANAGEMENT

Carrier's Austin Representative Box

Box Number 43

MFDR Tracking Number

M4-12-0030-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This Claim was originally billed incorrectly. Upon notice the claim was corrected and resubmitted as a corrected claim. Carrier refuses to pay the corrected/full amount due for services rendered even after a request for reconsideration was submitted."

Amount in Dispute: $103.25

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is the respondent's position that the payments made to the provider for the services rendered on 5/27/2011 has been paid in full…The software used by JI Specialty Services identifies the per unit value for 97750 as $50.50 = $707.00. The payments already made to the provider in the amount of $707.15 exceed the MAR…"

Response Submitted by: JI Specialty Services on behalf of Texas Council Risk Management Fund; PO Box 26655; Austin TX 78755

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 27, 2011	97750-FC	$103.25	$ 0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204 set out the fee guidelines for the reimbursement of workers'

compensation specific codes, services and programs provided on or after March 1, 2008.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated July 14, 2011
   - 18 – Duplicate claim/service
   - 247 – A payment or denial has already been recommended for this service
   - D1 – Duplicate control number 123974

   Explanation of benefits dated July 19, 2011 and July 25, 2011
   - 193 – Original payment decision is being maintained. This claim was processed properly the first time.

   Explanation of benefits dated July 25, 2011
   - W1 – Workers compensation state fee schedule adjustment
   - 309 – The charge for this procedure exceeds the fee schedule allowance.

Issues

1. Did the requestor bill correctly for an FCE and has the requestor been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to additional reimbursement?

Findings

1. 28 Texas Administrative Code §134.204 (g) states, "The following applies to Functional Capacity Evaluations (FCEs). A maximum of three FCEs for each compensable injury shall be billed and reimbursed. FCEs ordered by the Division shall not count toward the three FCEs allowed for each compensable injury. FCEs shall be billed using CPT Code 97750 with modifier 'FC.' FCEs shall be reimbursed in accordance with §134.203(c)(1) of this title. Reimbursement shall be for up to a maximum of four hours for the initial test or for a Division ordered test; a maximum of two hours for an interim test; and, a maximum of three hours for the discharge…" The requestor originally submitted an FCE bill with an incorrect billed amount of $50.65 for 14 units. The insurance carrier reimbursed $50.65. The requestor subsequently submitted an amended claim for $810.40 for 14 units. The insurance carrier processed the amended claim and reimbursed an additional $656.50 for a total reimbursement of $707.15.
2. FCEs shall be reimbursed in accordance with §134.203(c)(1) of this title. The calculation is as follows: The 2011 DWC conversion factor is $54.54 divided by the Medicare conversion factor of $33.9764 multiplied by the participating amount of $31.46 equals $50.50 per unit. The requestor billed 14 units. $50.50 multiplied by 14 units equals $707.00. The carrier paid $707.15; therefore, no additional reimbursement is due.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	December 22, 2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.